STATE OF SOUTH DAKOTA CLASS SPECIFICATION

Class Title: Community Health Worker **Class Code:** XXXYYY
Pay Grade: GG

A. Purpose:

Provide public health services within the scope of a trained Community Health Worker, assisting health professionals within the clinic environment and connection to services provided by community-based organizations.

B. Distinguishing Feature:

Nutrition Assistant interviews clients, gathers information, and determines eligibility for certification in the WIC program.
Nutrition Educator provides nutrition counseling and education services to clients in the WIC program in an assigned region.

C. Functions:
(These are examples only; any one position may not include all of the listed examples nor do the listed examples include all functions which may be found in positions of this class.)

1. Provides individual direct services to support clients of the program.
   a. Providing support for clients to use provider instructions or advice and convey client challenges to providers.
   b. Facilitating communication with provider.
   c. Conduct screenings and prepare patients by explaining testing and clinic procedures for testing and treatment.
   d. Conduct and/or accompany Disease Intervention Specialists on home visits.
   e. Provide partner notification and education relevant to specific disease conditions.
   f. Answer routine questions, triage, and make appropriate referrals specific to the health and social needs of clients.
   g. Refer clients to resources specific to their health and social needs. Assist clients with completing applications for services through other agencies. Collaborate with health professionals to identify and link clients to community resources and support.
   h. Promote and facilitate tele-health services to overcome barriers to timely and effective service delivery
   i. Respond to telephone and in-person inquiries within scope of the position. Assist clerical/receptionist to screen, schedule, and interview diverse clientele to determine appointment type and appropriate provider.
   j. Assess infant sleep practices during contacts with families and provide education and safe sleep kit as needed.
   k. Contact high-risk pregnant women when they have missed appointments with the Registered Nurse. In consultation with the RN, works to identify and overcome barriers clients have to accessing service.

2. Provides coaching and social support including system navigation and resource coordination.
    a. Providing individual support and coaching to clients.
    b. Motivating and encouraging people to obtain care and other services.
    c. Supporting self-management disease prevention education.
    d. Promote healthy decisions.
    e. Answer routine questions, triage, and make appropriate referrals specific to the health and social needs of clients.
    f. Set priorities for appointment scheduling in consultation with health professionals when clients have competing needs and appointments slots are not available to meet all requests timely.
    g. Maintain a list of local resources and referral information.
    h. Providing information to individuals and communities about accessing health systems, social service systems, and human resources.
    i. Ensuring individuals follow-up with care provider recommendations.
    j. Facilitating transportation to services and addressing other barriers to service.
    k. Documenting and charting data.
    l. Informing individuals and systems about community assets.
    m. Assisting individuals to better understand their private and/or public health insurance coverage and options.
    n. Sharing knowledge of resources about healthcare related topics.
    o. Helping individuals navigate transition of care.
    p. Assist in implementing a care management plan in collaboration with provider/other resources.
    q. Knowledge of local health systems/resources.
    r. Assisting in developing and implementing care plans.
    s. Making referrals and connections to community resources
    t. Fostering and establishing relationships and communication
    u. Providing follow-up and collaboration with provider/other resources
    v. Collaborate with health professionals and community partners.
    w. Navigation use of multiple software systems.
    x. Lead the outreach and coordination to provide public health events such as school health services, immunization clinics, testing events, other.

3. Provide culturally appropriate health education and information to clients and staying up to date on all resources that are available.
    a. Reviewing professionally prepared health promotion and disease prevention information that matches linguistic and cultural needs of the community and/or its members.
    b. Providing nationally recognized and/or provider-specific information to understand and prevent diseases and to help individuals manage their health conditions.
    c. Attaining culturally appropriate (language) education materials.
    d. Linking community perspectives and cultural norms into our public health services.
    e. Knowledge of health promotion and disease prevention principles while honoring cultural and religious beliefs.
    f. Knowledge of cultural practices within the community.
    g. Identify barriers for clients and connect them with the appropriate resources.
    h. Identifying health literacy standards for written materials.
    i. Knowledge of translation and interpretation services.

j. Maintain familiarity with providers and agencies that offer sliding fee scale for appropriate client referrals.

4. Performs other work as assigned.

D. Reporting Relationships:

Reports to a Program Manager, Nursing Manager, or a Community Health Nurse and typically does not supervise other staff.

E. Challenges and Problems:

Challenged to work with socially and culturally diverse populations, particularly when interpreter services are required. Many of the clients applying for the program are refugee's and from other third world countries who are newly in the United States and completely unfamiliar with foods they are prescribed, how to use them in meal preparation, and how to shop in a grocery store.

Typical problems include

F. Decision-making Authority:

Decisions include making referrals to social and health needs for each client including providing outreach to organizations about public health services.

Decisions referred include interventions and counseling for high-risk clients and clinical/healthcare services needed for clients

G. Contact with Others:

Daily/Weekly contact with clients who call, or walk-in seek information regarding public health services, resources, referral sources, information regarding public health threats or situations. Also, co-workers interacting with clients including clerical, public health assistants, nutrition educators, disease intervention specialists, nurses, dieticians to assist that client with referrals for additional services, culturally appropriate materials, system navigation, etc.
Annual contacts with assigned schools to request school rosters and student immunization records.

H. Working Conditions:

The incumbent works in a typical clinic environment with travel to remote areas of the state preforming home visits.

I. Knowledge, Skills and Abilities:

- effective communication to build good relationships with clients and team members;
- able to develop a strong knowledge base of multiple programs;
- critical thinking and problem-solving skills;

- work effectively with interpreter services and with culturally and socio-economically diverse populations
- able to work in multiple computer software applications; and
- ability to multitask, prioritize complex situations, and adapt to quickly shifting priorities.